MEDICAL EXPENSE CLAIM FORM

Instead of completing this form you may file your claim online at www.GenesisBenefits.net.
You may also track your payments, view plan balances and see claim history online anytime.

Please comply with the following instructions to file your claim for reimbursement. Failure to follow these instructions will delay processing of your claim and may result in your claim being returned to you. Additional information regarding allowable expenses is provided on the reverse of this form.

1. **Complete the entire claim form, including the itemized list of expenses**.
2. **Attach documentation, in the order it is listed on this form, supporting the expenses**. Acceptable documentation includes:
   - **For medical care --** an itemized bill from the provider or Explanation of Benefits from the insurance company showing the date of the service, provider name, type of service and/or procedure codes, and your out-of-pocket cost.
   - **For over-the-counter drugs and supplies -** the itemized receipt or drug receipt from the place of purchase showing the date, item purchased, and out of pocket cost.
3. **Note the claim line number in the upper right corner of each attachment**. For example, note "1" in the upper right corner of your documentation for the health care expense listed first on the claim form.
4. If additional space is needed for your itemization, attach a separate sheet using the same format as the itemization on the claim form. Continue the claim line numbers on the additional sheet.
5. **SIGN and DATE the claim form after carefully reading the Employee Certification on the reverse.**
6. Keep a copy of this form and all supporting documentation for your records.
7. **Eligible claims and substantiation received by 1pm CST on Thursday will be reimbursed the following week on Friday.**

Employer Name: _____ ❑ **I Am Retired**

Employee Name: _____ **SSN:** _____

Home Address: _____

_____ ❑ **Address Change**

Email Address: _____ **Telephone:** _____

MEDICAL EXPENSES

Line # note on receipts	Service Date(s)	Provider	Type of Service (Medical, Dental, Vision, Orthodontia, Rx, Over the Counter)	Patient Name	Amount Requested
1					
2					
3					
4					
5					
6					
7					
8					
9					
				Total Medical Expense Claim	**$**

☐ **I am also enrolled in the VEBA Health Savings Plan (VHSP)/115 and request that any claimed amount that exceeds my available Medical FSA balance be automatically reimbursed from my VHSP account.**

EMPLOYEE CERTIFICATION OF EXPENSES AND CLAIM FOR REIMBURSEMENT

I certify that I have read and understand the Employee Certification on the reverse side of this form.

Employee Signature: _____ **Date:** _____

FAX, EMAIL OR MAIL completed claim forms & supporting documentation to:

Local Claims eFax: 952-460-1480
Toll-Free Claims eFax: 866-450-1480
Email: Claims@GenesisBenefits.net

Genesis Employee Benefits, Inc
PO Box 1578
Minneapolis, MN 55440-1578

Local Phone: 952-653-4422
Toll-Free Phone: 866-678-8322
CustomerCare@GenesisBenefits.net

Check the status of your claim online at www.GenesisBenefits.net. Choose Participant Login in the upper right corner.

MEDICAL

EMPLOYEE CERTIFICATION

Read this statement carefully then sign in the appropriate place on the front of this form.

I certify that I am claiming reimbursement only for eligible expenses incurred during the applicable plan year for qualifying individuals. I certify that these expenses have not been reimbursed and I will not seek reimbursement for them under any other health plan. I understand that the expense for which I am reimbursed may not be claimed as an income tax deduction. I understand that if I am reimbursed for an ineligible expense and the IRS audits my personal income tax return, I may be subjected to taxation on the reimbursement amount. I have provided sufficient documentation to support all expenses for which I am requesting reimbursement.

MEDICAL ELIGIBLE EXPENSES

Expenses allowed by your employer sponsored plan may vary from those permitted by the IRS.
Consult your plan document to determine what expenses are allowed by your plan.

- Expenses must be incurred by you, your spouse, or eligible dependents for whom an exemption can be claimed on your tax return.
- Expenses must be incurred primarily for medical care as defined by the IRS, which includes "amounts paid for the diagnosis, cure, mitigation, treatment, prevention of disease, or for the purpose of affecting any structure or function of the body."
- Expenses for personal items are not reimbursable even if recommended by your physician. Generally, an expense is deemed "personal-only" if it would have been incurred in the absence of a medical condition. Examples are health club dues and dental hygiene products.
- Expenses for dual-purpose items, which may be personal or medical in nature, require substantiation of medical necessity. Examples are blood pressure monitors, acne medication, weight loss drugs or programs, massage therapy, and over-the-counter orthotics such as ankle or knee braces. Medical necessity can be substantiated through a letter or other documentation of illness or disease from your practitioner.
- Over-the-counter items obtained for a medical purpose are reimbursable if allowed by your plan document. Examples of OTC items with medical-only uses include allergy medications, nicotine patches or gum, thermometers, Pedialyte, and reading glasses.
- Sufficient documentation to substantiate the medical necessity of the expense must be provided in order for your claim to be processed.

You may not claim expenses which have been reimbursed or are reimbursable under any other source. If you do not comply with this requirement and the IRS audits your tax return, you will be liable for any and all back taxes due on ineligible expenses.

FAX or MAIL
COMPLETED CLAIM FORMS & SUPPORTING DOCUMENTATION TO:

SECURE LOCAL eFAX 952-460-1480
SECURE TOLL-FREE eFAX 866-450-1480

Genesis Employee Benefits, Inc.
PO Box 1578
Minneapolis, MN 55440-1578

CUSTOMER CARE CENTER
Local 952-653-4422
Toll-Free 866-678-8322